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DATE: January 2, 1969

TO : Dr. Joshua Lederberg

FROM : L. J. Schneiderman, M.D.

SUBJECT: ACME Policy Committee Meeting

Dear Josh:

I am sending you this memo informing you of a meeting held Monday, December 30, at 2 p.m. in which we discussed the possibility of integrating the computer-serviced billing procedures with other patient care operations on the ACME system. In attendance: Victor Barber (who reports directly to Courtney Jones), Mr. Frank Petro, Mr. Bob Baker (two consultants from the Arthur Young Co.), Gio Wiederhold, Sandy Mesel, and myself.

I opened the meeting raising the following points:

1) The ACME Policy Committee was frankly casting about for new funding sources in the present budgetary crunch, and felt that future hospital operations might well provide a source of revenue for the ACME system.

2) It was emphasized that the ACME computer facilities was a functioning, first-rank system which could provide a wide variety of data processing services and that it certainly seemed desirable to consider having all Stanford University Medical Center operations using this system.

3) The possibility of merging administration and clinical data on all Stanford Medical Center patients offered an outstanding opportunity to pursue new directions in the evaluation of patient care, clinical research, and the delivery of health services.

4) The particular kinds of services required for computer-operated patient billing was batch processing and that ACME already could serve these needs during the overnight period of time when the system is nearly idle.

Our discussion then covered the following main points:

1) Mr. Barber mentioned that a report was completed for Courtney Jones within the past few weeks dealing with the recommendations for the reorganization of inpatient billing procedures. No assessment of the ACME system and no consideration of it as a computer service facility was considered in this report. However, as a result of our meeting an addendum will be prepared to the report dealing with recommendations regarding the ACME system. Mr. Barber indicated that their mandate was to deal exclusively with the billing procedures of the hospital and to seek the most cost-effective solution without regard for other objectives such as facilitating clinical research, etc. He seemed to be very receptive, however, to our suggestions that long-term economic gains as well as medical gains could result from integration of administrative and clinical data.

2) A hurdle that has to be met is the problem of conversion of the billing procedures from a 1401 to any other system. This will be discussed in

further detail with Gio, who indicated that there was a program translator available which would facilitate transfer to ACME PL1.

3) The possibility of handling billing procedures on a third shift was discussed and Gio emphasized again that all such data processing could well be handled overnight on the present ACME system.

4) The reliability of the ACME system was discussed and all parties indicated that the present approximate 2% down time was satisfactory to all parties.

5) The question was raised of support personnel for the ACME system and Gio's response seemed to satisfy all parties.

6) The question of storage was also raised and it is conceded that the ACME storage capacity was more than adequate and that future modifications were relatively easy if necessary.

7) The stability of ACME funding was discussed and it was conceded that the major budgetary support comes from NIH, which makes everyone cringe a bit in these critical days. However, we emphasized that any melding of patient data into the research environment could only strengthen ACME's chance for continuing support in the light of the current direction of government funding objectives. It was also emphasized that the university, IBM, and NIH all have a heavy investment in the success of ACME at Stanford, that the present potential deficit is only a small fraction of the total operating costs, that all things considered the U. S. government was as reliable a patron as any other funding body, and that, therefore, future reliance could probably be placed on the continuing funding of the ACME system.

8) Emphasis was again placed on the potential benefits to be gained through the merging of data into a file accessible to clinical researchers. Several examples were cited as to how this function could serve the interests of hospital administrators, those interested in the future design of medical care facilities, and clinicians in general.

9) It was pointed out that the relationship of administrative officers to the ACME system was one that could be negotiated on many levels:

   a) Contract arrangements could be made which would guarantee continuing ACME funding in return for a guarantee of certain services for a given length of time to hospital administration.

   b) Hospital administration representatives could attend Policy Committee meetings and their influence would certainly be related in large part to the amount of funding support they provide.

10) It was recommended that in the very least an offer should be given to the ACME system in exchange for services. Since ACME stands idle much of the night, some cash might be accepted as being better than nothing.

11) Mr. Barber acknowledged that their mandate was to develop a system for the most economic way of billing patients, that they were not to "subsidize" research. We all agreed that narrowly defined short-term

objectives were perhaps unsound in a university hospital setting when the opportunity existed for important discoveries and significant advances. My earlier discussions with Courtney Jones indicated that he, too, was receptive to this.

12) I mentioned that Courtney Jones had raised the point of mixing patient administration data with medical research data at a recent meeting he attended with other hospital administrators and that the general emotional response was negative. I asked whether there were any more hard data or solid experience with this problem and apparently there were not. Mr. Barber expressed the feelings that the reaction may have represented the feelings of a conservative body of administrators whose natural tendency was to keep things simple.

ADDENDUM:

I have talked to as many of the key members of the CCAC that I could get to during the Christmas vacation with regard to the future directions of ~~the~~ clinical computer applications at Stanford. My general feeling is that most people were happy with the present manner of development, i.e., independent investigators pursuing and exploring their own avenues, maintaining contact with each other, collaborating when possible. Other than "more of the same" answers for future computer needs I was given one idea which I pass on to you, as I think it is a good one, namely, that a subcommittee of the CCAC be appointed to review all grant applications for projects requiring significant uses of computer services. This would tend to open lines of communication between users, also with potential granting agencies, and might in many instances serve to improve the efficiency with which computer services are utilized.

I should enjoy hearing any thoughts you might have about these matters.